Date		
11/19/19 1230	#1 DDAVP 0.8mg PO QHS x 365 #2 f/u to urology in 3 months RBVO Dr. Rees/BBRN #3	Name Smith, Jacob AO 411666 Allergies: Unit - WRC A B (C) D INF HSU1 HSU2 LHU2 MDIU LHU1 Medication Issued From Stock 1 #_____ 2 #_____ 3 #_____ Date 11/19/19 Initials BBRN

Date		
12/19/19	#1 PAIN CLINIC 1-2 wks Dx BILAT. KNEE EFFUSION #2 ~~LABS.~~ CBC BMP PRICK #3	Name Smith, Jacob AO 411666 Allergies: Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1 Medication Issued From Stock 1 #_____ 2 #_____ 3 #_____ Date 12/19/19 Initials KW

Date		
2/6/20	#1 Please schedule with Dr. Rees to re-evaluate #2 need for tx. of left index finger. #3 T. Breese RN	Name Smith, Jacob AO 411666 Allergies: Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1 Medication Issued From Stock 1 #_____ 2 #_____ 3 #_____ Date 2/6/20 Initials TB

Date		
2/28/20	#1 ANA, ESR, RF Dx CHRONIC KNEE EFFUSION #2 #3	Name Smith, Jacob AO 411666 Allergies: Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1 Medication Issued From Stock 1 #_____ 2 #_____ 3 #_____ Date 2/28/2020 Initials KW

Montana Department of Corrections

Nursing and Provider Progress Notes

T: 98.2	P: 56	RR: 16	BP: 117/69	O2 Stats: 99	Height: 6'0"	Weight: 220	Age: 44

Routine Follow Up: Schedule back with Dr. Rees to discuss kite daed 7.23.19 and urinary plan of care see 3.4.19 note from Dr. Readal per SP 7.26.19

PT REPORTS 50% RELIEF IN NOCTURNAL POLYURIA ; DDAVP q HS PT HAS BEEN ON MED CONTINUOUSLY FOR 2-3 DAYS PREVIOUSLY WHEN OUT EXPERIENCED NA's.

Px & BENIGN FUNDUS. 1+ RRL - CLEAR A. S/NT E - BILAT MOD. KNEE EFFUSIONS. GOOD ROM & LIG INSTABILITY.

A) DETRUSOR INSTABILITY
BILAT. KNEE EFFUSIONS ≈ 4 YRS
& Hx OF RA.

P) REPEAT BILAT KNEE X RAYS

Provider Signature: [signature] MD

Offender Name / DOC ID#: Smith, Jacob Lee - 41666	Date: 11/21/2019	Time:

SCHEDULE FOR ARTHROCENTESES TOMORROW
BACTRIM DS PO IN AM / AT TIME OF PROCEDURE AND AT HS.
F/U FOR DETRUSOR INSTAB. 4 WKS ; CBC, BMP ESR RF PRIOR

[signature]

CONFIDENTIAL MEDICAL INFORMATION - UTILIZE CARE IF DESSEMINATING

Montana Department of Corrections

Nursing and Provider Progress Notes

T: 98.2	P: 60	RR: 16	BP: 109/67	O2 Stats: 98	Height: 6'0"	Weight: 220	Age: 44

Routine Referral: Please schedule with Dr. Rees to re-evaluate need for TX of left index finger per TB 2.6.20

INSURED 2016. I SAW 2/10/17

Rx: DC ACTIVE/PASSIVE STRETCHING PROGRAM.

(1) INDEX FINGER c LIMITED FLEXION

BOTH ACTIVE & PASSIVE 2/2 PAIN.

Ø SIG ARTHRITIS.

BOTH KNEES c RECURRENT EFFUSIONS.

GOOD ROM.

A) CHRONIC EXTENSOR CONTRACTIONS @ INDEX FINGER

CHRONIC KNEE EFFUSIONS

P) ANA ESR RF

APPT c ORTHO DR JONES

TRIAL OF INDOCIN 25 TID x 14 D

F/U c PCP AFTER ORTHO APPT.

Provider Signature: Paul Rees

Offender Name / DOC ID#: Smith, Jacob Lee - 41666	**Date:** 02/28/2020	**Time:**

CONFIDENTIAL MEDICAL INFORMATION - UTILIZE CARE IF DESSEMINATING

Montana State Prison
Nursing & Provider Progress Notes

Date/Time	Progress Notes
11/22/19	@ Pt shave both knees drained.
	BP: 119/74 P: 64 Sat: 99% T: 98.2 wt: 250

Inmate Name: Smith (Last) Jacob (First) DOC ID#: 4160646

DEFENDANTS 2208

exhibit 4

Inmate Name JACOB SMITH
DOC ID# 41666

DEPARTMENT OF CORRECTIONS
MONTANA STATE PRISON

INFORMED CLINICAL CONSENT

I understand that the following clinical procedure; ARTHROCENTESIS / STEROID INJ. RIGHT KNEE
Is recommended by Dr. Rees ✓ Requested by myself ___
(MDOC Health Care Provider Name)

I have received a clear explanation of my condition, the recommended clinical procedure, the probability of success, treatment alternatives and post procedure expectations/care.

The expected benefit(s) from this clinical procedure is/are: **Removal of lesion**___ **Drainage of lesion**___ **Relief of joint inflammation** ✓ _____

_____

I have been advised of any significant risks in relation to this clinical procedure. The following reasonably foreseeable risks were discussed: **Death, Infection, Scarring, Pain, Loss of function, Nerve damage, Incomplete removal requiring repeat excision** ✓

_____

I understand that if the procedure is NOT performed the possible risks are: **Progression of lesion/condition, Failure to accurately diagnose,** _____

_____

I am aware of my right to give informed consent or informed refusal I, **DO** ✓ **DO NOT**___ give my informed consent to the recommended procedure.

Patient comment: _____

Signature of Patient _____ Date/Time 11/22/19

Signature of Witness _____ Date/Time 11/22/19

Patient Refused to Sign _____ Date/Time _____
Witness Signature

DOC 4.5.31 (Attachment) Informed Consent – Revised 4/29/14 **(Mod by Rees 11/15/19)**

DEFENDANTS 2274

exhibit 5

Montana Department of Corrections

Nursing and Provider Progress Notes

T:	P:	RR:	BP: /	O2 Stats:	Height:	Weight:	Age:

Sick Call Referral: DDVAP not working well- knees swollen again- requests results of lab per RH 12.4.19

Provider Signature:

Offender Name / DOC ID#: Smith, Jacob Lee - 41666	**Date:** 12/10/2019	**Time:**

NAME: [illegible] **NUMBER:** [illegible] **UNIT:** UC

IN REGARDS TO YOUR REQUEST/KITE

[illegible]

- ☐ AN APPOINTMENT AT SICK CALL HAS BEEN SCHEDULED FOR YOU.
- ☐ THE INFIRMARY NO LONGER SUPPLIES THIS.
- ☐ YOU HAVE RECEIVED ALL OF THE MEDICATION ORDERED FOR YOU.
- ☐ THE ITEM(S) CAN BE PURCHASED FROM THE CANTEEN.
- ☐ SEE YOUR UNIT SERGEANT.
- ☐ SEE YOUR UNIT COUNSELOR.
- ☐ IF YOU HAVE FURTHER QUESTIONS, CONTACT THE INFIRMARY VIA KITE.

THE INFIRMARY

NU